VZV Specimen Collection Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

UNIQUE IDENTIFIER (ASSIGNED BY CDC) _____

PATIENT INFORMATION

Last Name: _____

First Name: _____

Date of Birth: ____/____/____

Sex: ☐ Male ☐ Female

PROVIDER INFORMATION

Name: _____

Institution: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

E-mail: _____

SPECIMEN INFORMATION

Date Collected: ____/____/____

Source of Specimen:

- ☐ Skin Lesion:
  - ☐ Vesicle (fluid-filled blister)
  - ☐ Papule (bump)
  - ☐ Macule (flat lesion)
  - ☐ Crust/Scab
- ☐ Blood
- ☐ Cerebrospinal Fluid
- ☐ Other *(specify)*: _____

Reason for Specimen Submission:

- ☐ Suspected transmission of vaccine virus
- ☐ Suspected vaccine adverse event
- ☐ Suspected vaccine failure
- ☐ Lab confirmation
- ☐ Determine patient's susceptibility
- ☐ Strain identification (wild type vs. vaccine strain)
- ☐ Other *(specify)*: _____

If an **adverse event** is suspected, has a VAERS report been submitted? ☐ Yes – VAERS number: _____ ☐ No

CLINICAL HISTORY

Date of Rash Onset: ____/____/____

Type:

- ☐ Macules Approximate Number: _____
- ☐ Papules Approximate Number: _____
- ☐ Vesicles Approximate Number: _____

Diagnosis:

- ☐ Varicella ☐ Zoster (Shingles)
- ☐ Other *(specify)*: _____

Previous Chickenpox:

Has the patient ever had **chickenpox** before this illness/rash?

☐ Yes ☐ No ☐ Unknown

If yes, at what age? _____

Medications:

Did the patient take **steroid**(s) or **immunosuppressant**(s) during the month prior to rash onset? ☐ Yes ☐ No

If yes, check all that apply and specify **name**, **dose**, and **route** of administration for each medication:

- ☐ Steroid(s) *(specify)*: _____
- ☐ Immunosupressant(s) *(specify)*: _____
- ☐ Other(s) *(specify)*: _____

In the week before the specimen was collected, did the patient take **oral acyclovir**, **famciclovir**, or **valacyclovir**? ☐ Yes ☐ No ☐ Unknown

If yes, specify: _____

Additional Clinical Information: _____

VACCINE INFORMATION

Has the patient received the varicella vaccine? ☐ Yes ☐ No ☐ Unknown

Dose 1: Date ____/____/____ Lot Number _____

Dose 2: Date ____/____/____ Lot Number _____

MAIL FORM AND SPECIMEN TO:

CDC • National VZV Laboratory
1600 Clifton Road, NE • MS G-18
Atlanta, GA 30333
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